SERFF Tracking Number:	*HMRK-125613502*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*38733*
Company Tracking Number:	*HM904- XLA*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Stop Loss Application Filing*		
Project Name/Number:	*Stop Loss Applications/HL904 (AR)*		

Filing at a Glance

Company: HM Life Insurance Company

Product Name: Stop Loss Application Filing	SERFF Tr Num: HMRK-125613502	State: ArkansasLH
TOI: H21 Health - Other	SERFF Status: Closed	State Tr Num: 38733
Sub-TOI: H21.000 Health - Other	Co Tr Num: HM904- XLA	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Jennifer Bayich	Disposition Date: 04/21/2008
	Date Submitted: 04/17/2008	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Stop Loss Applications
Project Number: HL904 (AR)
Requested Filing Mode:

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Filing Status Changed: 04/21/2008
State Status Changed: 04/21/2008
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments: Exempt from filing in PA.
Market Type: Group
Group Market Size: Small and Large
Group Market Type: Employer, Association, Blanket

Deemer Date:

Filing Description:

Dear Sir or Madam-

Attached with this filing please find Stop Loss Applications being filed for approval for use in Arkansas. These applications are being re-filed in compliance with Arkansas Bulletin 06-2008. The notice requirement as worded in the Bulletin has been added to these applications. These application forms have also been updated to reflect our new

SERFF Tracking Number:	*HMRK-125613502*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*38733*
Company Tracking Number:	*HM904- XLA*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Stop Loss Application Filing*		
Project Name/Number:	*Stop Loss Applications/HL904 (AR)*		

Company name, HM Insurance Group. The name change was approved by Arkansas on March 10, 2006. These are the only changes to these forms.

If you require further information or have any questions, please contact me.

Thank you and have a good day.

Company and Contact

Filing Contact Information

Jennifer Bayich, Compliance Analyst II
P.O. Box 535061
Pittsburgh, PA 15235-5061

jennifer.bayich@hminsurancegroup.com
(412) 544-0923 [Phone]
(412) 544-1138[FAX]

Filing Company Information

HM Life Insurance Company
PO Box 535065
Suite P6504
Pittsburgh, PA 15253-5065
(412) 544-1139 ext. [Phone]

CoCode: 93440
Group Code: 812

Group Name: HM Insurance Group
FEIN Number: 06-1041332

State of Domicile: Pennsylvania
Company Type:

State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$60.00
Retaliatory?	No
Fee Explanation:	3 forms x $20
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
HM Life Insurance Company	$60.00	04/17/2008	19643454

SERFF Tracking Number:	*HMRK-125613502*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*38733*
Company Tracking Number:	*HM904- XLA*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Stop Loss Application Filing*		
Project Name/Number:	*Stop Loss Applications/HL904 (AR)*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/21/2008	04/21/2008

SERFF Tracking Number:	*HMRK-125613502*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*38733*
Company Tracking Number:	*HM904- XLA*		
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Product Name:	*Stop Loss Application Filing*		
Project Name/Number:	*Stop Loss Applications/HL904 (AR)*		

Disposition

Disposition Date: 04/21/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*HMRK-125613502*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*38733*
Company Tracking Number:	*HM904- XLA*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Stop Loss Application Filing*		
Project Name/Number:	*Stop Loss Applications/HL904 (AR)*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

SERFF Tracking Number:	*HMRK-125613502*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*38733*
Company Tracking Number:	*HM904- XLA*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Stop Loss Application Filing*		
Project Name/Number:	*Stop Loss Applications/HL904 (AR)*		

Form Schedule

Lead Form Number: HM904- XLA

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	HL904 XLA (AR)	Application/ Enrollment Form	Application	Revised	Replaced Form #: HL904 XLA (AR) Previous Filing #: HL904 XLA		Microsoft Word - Application HL904 XLA 4.08 Ame.pdf
Approved-Closed	HL-SLA WD (AR)	Application/ Enrollment Form	Application	Revised	Replaced Form #: HL-SLA WD (AR) Previous Filing #: HL-SLA-WD		Microsoft Word - Amended Application HL SLA WD .pdf
Approved-Closed	HL-SLA ND (AR)	Application/ Enrollment Form	Application	Revised	Replaced Form #: HL-SLA ND (AR) Previous Filing #: HL-SLA ND		Microsoft Word - Amended App HL SLA ND .pdf

APPLICATION TO
HM LIFE INSURANCE COMPANY
FIFTH AVENUE PLACE 120 FIFTH AVENUE
PITTSBURGH, PA 15222
FOR
AGGREGATE AND SPECIFIC EXCESS LOSS INSURANCE

Application is hereby made to HM Life Insurance Company ("Company") for Excess Loss Insurance. This Application must be accepted and approved by the Company or its authorized representative prior to any Contract being in existence.

1. Full Legal Name of Applicant: ___[Specimen]_____

2. Address: _____[Any Street]_____
   Street

   ____[Any City]_____ __[Any State]_____ _[12345]_____

   City State Zip Code

3. If employee benefit plans of subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal name and addresses of such companies.
   _____[Specimen Company]_____
   _____
   _____

4. Enter the full name of your Employee Benefit Plan(s) - (A copy of such Employee Benefit Plan(s) must be attached.)
   _____[Contractholder's medical plan]_____

5. Name and address of Designated Third Party Administrator:

   _____[Specimen]_____

6. Effective Date: _____[Date]_____

7. Estimated Initial Enrollment (will be used as the Number of Covered Units during the first Contract Month):

   _____[*]_____ Singles and _____[*]_____ Families (or) _____[*]_____ Composite

8. **GENERAL SCHEDULE OPTIONS:**

   (a) Disabled Persons ❑ are ❑ are not covered.

   Retired Employees ❑ are ❑ are not covered.

   (b) Aggregate Benefit ❑ Yes ❑ No

Aggregate Contract Basis: Employee Benefit Plan Expenses must be
Incurred from ___[Date]_____ through _____[Date]_____, and
Paid from _____[Date]_____ through _____[Date]_____ .

Claims Incurred prior to the Contract Effective Date are limited to $ _____[*]_____

Aggregate eligible expenses include:

❑ Medical	❑ Prescription Card Service
❑Dental Care	❑ Weekly (Disability) Income
❑ Vision Care	❑Other: _____

Aggregate Monthly Factor per:	Single Employee:	$ _____[*]_____
	Family:	$ _____[*]_____
	Composite:	$ _____[*]_____

Aggregate Payable Percentage (excess of Deductible):	_____**[[100]**_____ %
Maximum Eligible Claim Expense Per Covered Person:	$ _____[*]_____
Minimum Aggregate Deductible:	$ _____[*]_____
Maximum Aggregate Benefit (excess of Deductible):	$ _____[*]_____

(c)	Monthly Aggregate Accommodation	❑ Yes	❑ No
(d)	Terminal Liability	❑ Yes	❑ No
(e)	Specific Benefit	❑ Yes	❑ No

Specific Contract Basis: Employee Benefit Plan expenses must be:
Incurred from _____[Date]_____ through _____[Date]_____, and
Paid from _____[Date]_____ through _____[Date]_____.

Claims Incurred prior to the Contract Effective Date are limited to:	$ _____[*]_____
Specific Eligible Expense: [Medical Only]	
Specific Deductible (per person):	$ _____[*]_____
Specific Payable Percentage (excess of Deductible):	_____**[100]**_____ %
Maximum Specific Benefit (per person in excess of Specific Deductible):	$ _____[*]_____

9. **PREMIUMS:**

(a) Aggregate Premium

Premium Per Month Per Unit:	$ _____[*]_____
Minimum Annual Aggregate Premium:	$ _____[*]_____

Monthly Aggregate Accommodation

Premium Per Month Per Unit:	$ _____[*]_____
Annual Premium in Advance:	$ _____[*]_____

Terminal Liability

Premium Per Month Per Unit:	$ _____[*]_____
Annual Premium in Advance:	$ _____[*]_____

(b) Specific Premium

Premium Per Month Per	Single Employee:	$ _____[*]_____
	Family:	$ _____[*]_____
	Composite:	$ _____[*]_____
Minimum Monthly Specific Premium:		$ _____[*]_____

10. **SPECIAL RISK LIMITATIONS:**

Contract will be based upon the current employee benefits as defined in the Employee Benefit Plan by reference or by attachment, except as noted below:

Specific: [Medical includes Outpatient Prescription Drugs}_____
_____

Aggregate: [Medical includes Outpatient Prescription Drugs}_____
_____

11. **IT IS UNDERSTOOD AND AGREED, AS CONDITIONS PRECEDENT TO THE APPROVAL OF THIS APPLICATION, THAT:**

(a) All documentation, including but not limited to disclosure and large claim notification, as of the date specified by the Company must be submitted prior to any approval of this Application and must be received by the Company within 90 days of the requested Effective Date.

(b) If the Schedule shows disabled persons are not covered, no benefits will be paid under the Contract for expenses Incurred or Paid under the Employee Benefit Plan for a disabled person until:

(1) if an employee, he or she returns to active, full-time employment for at least one (1) full working day; or
(2) if a dependent or Continuation Beneficiary„ he or she is able to perform the normal functions of a person of like sex and age.

(c) Issuance of the Contract is in reliance upon the underwriting information provided by the Applicant or its Agent. Should subsequent information become known which, if known as of the date specified by the Company for disclosure, would have affected the rates, deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, deductibles, terms or conditions as of the Effective Date, by providing written notice to the Applicant.

(d) The Contract, if issued, may be void, if whether before or after a claim or loss, any material fact or circumstance was concealed or misrepresented on behalf of the Applicant, or if the Applicant or its Agent, committed fraud.

(e) Receipt of a premium and its deposit in connection with the Application shall not constitute an acceptance of liability. In the event that Highmark Life Insurance Company disapproves this Application, its sole obligation shall be to refund such sum to the Applicant.

(f) If a Contract is issued and later rescinded, the sum of all benefits paid will be deducted from the sum of all premiums paid. If the result is positive, such amount will be paid by the Company to the Applicant. If the result is negative, such amount will be paid by the Applicant to the Company.

(g) The initial premium will be paid on or before the Effective Date, and subsequent premiums are due no later than the first day of each calendar month during the Contract Year.

(h) Applicant acknowledges that the Contract which is the subject of this Application is a reimbursement Contract. Applicant must first pay claims before submitting them for reimbursement.

(i) Oral Statements not expressly incorporated herein are not part of this Contract. Only the President or Executive Officer of the Company may make changes to the Contract Form or Addenda on behalf of the Company. All changes to this Contract must be in writing and attached to this Contract.

(j) NEITHER THIS APPLICATION NOR THE TERMS OF THIS APPLICATION MAY BE ALTERED.

In making this Application, the Applicant represents that, to the best of its knowledge and belief, such information accurately reflects the true facts and that the undersigned has authority to bind the Applicant to the proposed Contract. Accordingly, this Application will be a part of the Contract if accepted by the Company or its authorized representative.

Dated at _____[City, State]_____ this _____ day of _____, 20____

Witness: _____ Applicant: _____
Signature of Agent

Applicant's Tax ID #:_____

By: _____
(Officer/Partner)

Title: _____

Agent's Name: _____
(Type or Print)

Agent's Address: _____
Street

_____ _____ _____
City State : Zip

_____ _____
Agent's Social Security or Tax ID # Agent's License #

ACCEPTANCE

Accepted on behalf of the Company, this _____ day of _____ , 20 _____

By: _____

Title: _____

Contract No: _____ Effective Date: _____

Dated at _____, on _____, 20 _____.
(City, State) (Month, Day)

FRAUD STATEMENT

Except as otherwise indicated below, any person who knowingly and with intent to defraud or deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

In Florida, any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

In New Jersey, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

In Kentucky and Pennsylvania, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

ARKANSAS NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

HM LIFE INSURANCE COMPANY

PO BOX 535061, SUITE P6518
PITTSBURGH, PA 15253-5061

Application for Stop Loss Insurance
Please Type or Print – Must be completed in full

1. Applicant

_____	_____	( )_____
Full Legal Name of Group (to appear on the Policy)	Tax ID Number	Business Telephone
_____	_____	( )_____
Address	Zip + 4	Fax Number
_____		E-Mail _____
Delivery Address (If Different from Above)		Internet _____
_____		
Key Contact Person		
_____	_____	❑ Corp. ❑ Gov
Nature of Business	SIC Code	❑ Partner ❑ Other *

* If an Association, Trust or Charitable Organization a copy of the by laws and/or trust is required with the submission of the application. If a union, *or if union employees are covered,* a copy of the collective bargaining agreement is required with the submission of the application.

Affiliates to be Insured: □ No □ Yes (List below; if additional space is needed, please attached a separate sheet)

Full Legal Name and Address of Affiliates	**City/State**	**Nature of Business**
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Third Party Administrator (TPA)

_____	_____	( )_____
Full Legal Name of TPA	Tax ID Number	Business Telephone
_____	_____	( )_____
Address	Zip + 4	Fax Number
_____		E-Mail _____
Delivery Address (If Different from Above)		Internet _____
_____		
Key Contact Person		

3. Producer *(Agent / Broker)*

_____	_____	( )_____
Name	Tax ID Number	Business Telephone
_____	_____	( )_____
Address	Zip + 4	Fax Number
_____		E-Mail _____
License Number(s) (Please attach a copy if not on file)		Internet _____

4. Requested Effective Date: _____

5. Estimated Initial Enrollment: Single _____ Family _____ Total _____

6. Premium Deposit of $ _____ included. Estimated 1st month's premium *(must be attached to this application).* The Premium Deposit will be applied to the first premium when due. Make check payable to **HM Life.** Do not make the check payable to the Producer or leave the "Payee" blank. If a policy is not issued, the premium deposit will be refunded in full.

FRAUD NOTICE (*Please read carefully*)

Except as otherwise indicated below, any person who knowingly and with intent to defraud or deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

In Florida, any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

In New Jersey, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

In Kentucky and Pennsylvania, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

ARKANSAS NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

APPLICANT UNDERSTANDS AND AGREES THAT

The stop loss insurance requested and requested effective date must be approved by **HM Life Insurance Company** us under our current rules and practices. All options and special requests are subject to Home Office approval. No insurance agent or broker has authority to guarantee acceptability of requested insurance coverage.

Our approval is subject to receipt of Disclosure, the first month's premium, final census, and any other information requested in connection with this application. Failure to do so will result in approval being denied or delayed until a later date.

Receipt of a premium and its deposit in connection with the Application shall not constitute an acceptance of liability. In the event that **HM Life**, or our authorized agent, disapproves this Application, its sole obligation shall be to refund such sum to the Applicant.

Coverage will not be in effect until notified in writing by the Home Office. Do not cancel prior coverage until so notified.

Final premium rates will be determined on the basis of Disclosure, Claim Information and the actual composition of persons covered by the underlying employee benefit plan on the requested effective date. Should subsequent information become known which, if known as of the date specified by **HM Life**, or our authorized agent, would have affected the rates, deductibles, terms or conditions for coverage, we will have the right to revise the rates, deductibles, terms or conditions, by providing written notice to the Applicant. The Policy, if issued, may be void, if whether before or after a claim or loss, any material fact or circumstance was concealed or misrepresented on behalf of the Applicant, or if the Applicant or its Agent, committed fraud.

A signed and dated summary plan document describing the underlying employee medical plan must be submitted within 60 days of the Requested Effective Date. If the description of the benefits or plan provisions differs from what was initially utilized to underwrite the risk, the premium rates and aggregate retention factors may be subject to re-rating, retro-active to the requested effective date.

The stop loss insurance which is the subject of this Application is a reimbursement contract, and the Applicant must first pay claims and make funds available to pay claims as they become payable before submitting them for reimbursement. Oral statements not expressly incorporated herein are not part of this Application.

Issuance of the Policy is in reliance of the data, including Disclosure, census and Claim Information, submitted to us, and payment of the first month's premium; subsequent premiums are due no later than the first day of each calendar month during the Plan Year.

I represent that the statements contained in this application are true and complete to the best of my knowledge and belief, and I understand that they form the basis for **HM Life's** approval of the requested stop loss insurance.

_____
Print Name of Applicant's Authorized Representative

_____ _____ _____
Signature of Applicant's Authorized Representative | Date | Title

_____ _____
Signature of Witness (Licensed Producer) | Print Name of Witness

HM LIFE INSURANCE COMPANY

PO BOX 535061, SUITE P6518
PITTSBURGH, PA 15253-5061

Application for Stop Loss Insurance
Please Type or Print – Must be completed in full

1. Applicant

_____	_____	( )_____
Full Legal Name of Group (to appear on the Policy)	Tax ID Number	Business Telephone
_____	_____	( )_____
Address	Zip + 4	Fax Number
_____		E-Mail _____
Delivery Address (If Different from Above)		Internet _____
_____		
Key Contact Person		
_____	_____	❑ Corp. ❑ Gov
Nature of Business	SIC Code	❑ Partner ❑ Other *

* If an Association, Trust or Charitable Organization a copy of the by laws and/or trust is required with the submission of the application. If a union, *or if union employees are covered,* a copy of the collective bargaining agreement is required with the submission of the application.

Affiliates to be Insured: □ No □ Yes (List below; if additional space is needed, please attached a separate sheet)

Full Legal Name and Address of Affiliates	**City/State**	**Nature of Business**
_____	_____	_____
_____	_____	_____
_____	_____	_____

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_____	_____	( )_____
Full Legal Name of TPA	Tax ID Number	Business Telephone
_____	_____	( )_____
Address	Zip + 4	Fax Number
_____		E-Mail _____
Delivery Address (If Different from Above)		Internet _____
_____		
Key Contact Person		

3. Producer *(Agent / Broker)*

_____	_____	( )_____
Name	Tax ID Number	Business Telephone
_____	_____	( )_____
Address	Zip + 4	Fax Number
_____		E-Mail _____
License Number(s) (Please attach a copy if not on file)		Internet _____

4. Requested Effective Date: _____

5. Estimated Initial Enrollment: Single _____ Family _____ Total _____

6. Premium Deposit of $ _____ included. Estimated 1st month's premium *(must be attached to this application).*
The Premium Deposit will be applied to the first premium when due. Make check payable to **HM Life.** Do not make the check payable to the Producer or leave the "Payee" blank. If a policy is not issued, the premium deposit will be refunded in full.

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APPLICANT UNDERSTANDS AND AGREES THAT

The stop loss insurance requested and requested effective date must be approved by **HM Life Insurance Company** us under our current rules and practices. All options and special requests are subject to Home Office approval. No insurance agent or broker has authority to guarantee acceptability of requested insurance coverage.

Our approval is subject to receipt of the first month's premium, final census, Claim Information, and any other information requested in connection with this application. Failure to do so will result in approval being denied or delayed until a later date.

Receipt of a premium and its deposit in connection with the Application shall not constitute an acceptance of liability. In the event that **HM Life**, or our authorized agent, disapproves this Application, its sole obligation shall be to refund such sum to the Applicant.

Coverage will not be in effect until notified in writing by the Home Office. Do not cancel prior coverage until so notified.

Final premium rates will be determined on the basis of the information requested in connection with this Application and the actual composition of persons covered by the underlying employee benefit plan on the requested effective date. Should subsequent information become known which, if known as of the date specified by **HM Life**, or our authorized agent, would have affected the rates, deductibles, terms or conditions for coverage, we will have the right to revise the rates, deductibles, terms or conditions, by providing written notice to the Applicant. The Policy, if issued, may be void, if whether before or after a claim or loss, any material fact or circumstance was concealed or misrepresented on behalf of the Applicant, or if the Applicant or its Agent, committed fraud.

A signed and dated summary plan document describing the underlying employee medical plan must be submitted within 60 days of the Requested Effective Date. If the description of the benefits or plan provisions differs from what was initially utilized to underwrite the risk, the premium rates and aggregate retention factors may be subject to re-rating, retro-active to the requested effective date.

The stop loss insurance which is the subject of this Application is a reimbursement contract, and the Applicant must first pay claims and make funds available to pay claims as they become payable before submitting them for reimbursement. Oral statements not expressly incorporated herein are not part of this Application.

Issuance of the Policy is in reliance of the data submitted to us (including a final census, Claim Information and any other, information requested in connection with this Application) and payment of the first month's premium; subsequent premiums are due no later than the first day of each calendar month during the Plan Year.

I represent that the statements contained in this application are true and complete to the best of my knowledge and belief, and I understand that they form the basis for **HM Life's** approval of the requested stop loss insurance.

_____
Print Name of Applicant's Authorized Representative

_____	_____	_____
Signature of Applicant's Authorized Representative	Date	Title

_____	_____
Signature of Witness (Licensed Producer)	Print Name of Witness

SERFF Tracking Number:	*HMRK-125613502*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*38733*
Company Tracking Number:	*HM904- XLA*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Stop Loss Application Filing*		
Project Name/Number:	*Stop Loss Applications/HL904 (AR)*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*HMRK-125613502*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*38733*
Company Tracking Number:	*HM904- XLA*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Stop Loss Application Filing*		
Project Name/Number:	*Stop Loss Applications/HL904 (AR)*		

Supporting Document Schedules

Review Status:

Bypassed -Name: Certification/Notice — Approved-Closed — 04/21/2008

Bypass Reason: Not Applicable

Comments:

Review Status:

Satisfied -Name: Application — Approved-Closed — 04/21/2008

Comments:

Please see applicatins attached to form schedule.

Review Status:

Bypassed -Name: Health - Actuarial Justification — Approved-Closed — 04/21/2008

Bypass Reason: Not applicable.

Comments:

Review Status:

Bypassed -Name: Outline of Coverage — Approved-Closed — 04/21/2008

Bypass Reason: Not applicable to this submission.

Comments: